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CHAPTER V
SURGERY: RESPIRATORY, CARDIOVASCULAR, HEMIC AND LYMPHATIC SYSTEMS
CPT CODES 30000-39999
FOR
NATIONAL CORRECT CODING POLICY MANUAL
FOR PART B MEDICARE CARRIERS

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Chapter V
Surgery: Respiratory, Cardiovascular, Hemic and Lymphatic Systems
CPT Codes 30000 - 39999

A. Introduction

The general guidelines regarding correct coding apply to the CPT codes in the range of 30000-39999. Specific issues unique to this section of the *CPT Manual* are clarified in the following guidelines.

B. Respiratory System

1. Because the upper airway is bordered by a mucocutaneous margin, several CPT codes may define services involving biopsy, destruction, excision, removal, revision, etc. of lesions of this margin, specifically the nasal and oral surfaces. When billing a CPT code for these services, only one CPT code which most accurately describes the service performed should be coded, generally either from the CPT section describing integumentary services (CPT codes 10040-19499) or respiratory services (CPT codes 30000-32999). When the narrative accompanying the CPT codes from the respiratory system section includes tissue transfer (grafts, flaps, etc.), individual tissue transfer/graft/flap codes (e.g. CPT codes 14000-15770) are not to be separately coded.

2. In keeping with the general guidelines previously promulgated, when a biopsy of an established lesion of the respiratory system is obtained as part of an excision, destruction, or other type of removal, either endoscopically or surgically, at the same session, a biopsy code is not to be reported by the surgeon in addition to the removal code. In the case of multiple similar or identical lesions, the biopsy code is not separately reported even if performed in a different area. As noted previously, in the circumstance where the decision to perform the more comprehensive procedure (excision, destruction, or other type of removal) is dependent on the results of the biopsy, the procedure may be separately reported. If, at the same session, a biopsy is necessary to establish the need for surgery, the -58 modifier would be used to indicate this.

Example: If a patient presents with nasal obstruction, sinus obstruction and multiple nasal polyps, it may be reasonable to perform a biopsy prior to, or in conjunction with, polypectomy and ethmoidectomy; in this case a separate code (e.g. CPT code 31237 for nasal/sinus endoscopy) is not to be reported with the column 1 nasal/sinus endoscopy code (e.g. CPT code 31255) even though the latter code does not specifically list a biopsy in its CPT narrative because the biopsy tissue is procured as part of the surgery, not to establish the need for surgery.

3. When a diagnostic endoscopy of the respiratory system is performed, it is routine to evaluate the access regions as part of the medically necessary service; a separate service for this evaluation is not to be reported. For example, if an anterior ethmoidectomy is endoscopically performed, it is inappropriate to bill a diagnostic nasal endoscopy simply because the approach to the sinus was transnasal. As another example, fiberoptic bronchoscopy services routinely involve a limited inspection of the nasal cavity, the pharynx and the larynx; only the bronchoscopic code is reported, not with the nasal endoscopy, laryngoscopy, etc., for this service as this service is routine and incidental to the bronchoscopy.

If a diagnostic endoscopy is performed, and this results in a decision to perform a (non-endoscopic) surgical procedure, then this endoscopy could be separately reported, indicating that this represented a distinct diagnostic service. The -58 modifier may be used to denote that the diagnostic endoscopy and the non-endoscopic surgical procedure are staged or planned procedures. Diagnostic endoscopy of the respiratory system (e.g. sinus endoscopy, laryngoscopy, bronchoscopy, pleuroscopy, etc.) performed at the same encounter as a surgical endoscopy is included in the surgical endoscopy according to *CPT Manual* guidelines. However, when an open surgical procedure is performed and, at the same session, is accompanied by a "scout" endoscopy to evaluate the surgical field, the endoscopy code is not reported separately. This policy applies either if the endoscopic procedure is to confirm the anatomical nature of the patient's respiratory system or adequacy of the surgical procedure (e.g. tracheostomy, etc.). Additionally if an attempt to perform an endoscopic procedure fails and is converted to an open procedure, the endoscopic procedure is not separately reportable with the open procedure.

Example: If a patient presents with aspiration of a foreign body and a bronchoscopy is performed indicating a lobar foreign body obstruction, an attempt may be made to remove this bronchoscopically. It would be inappropriate to code and bill for CPT codes 31622 (bronchoscopy - diagnostic) and 31635 (surgical bronchoscopy with removal of foreign body); only the "surgical" endoscopy, CPT code 31635, would be appropriate. In this example, if the endoscopic effort is unsuccessful and a thoracotomy is planned, the diagnostic bronchoscopy could be separately coded in addition to the thoracotomy. The -58 modifier may be used to indicate that the diagnostic bronchoscopy and the thoracotomy are staged or planned procedures. If the surgeon decided to repeat the bronchoscopy after induction of general anesthesia to confirm the surgical approach to the foreign body, billing a service for this confirmatory bronchoscopy is inappropriate, although the initial diagnostic bronchoscopy could still be reported. Additionally, the failed bronchoscopic attempt to remove the foreign body should not be reported with an open procedure to remove the foreign body.

4. When a sinusotomy is performed in conjunction with a sinus endoscopy, only one service is reported. If the medically necessary service was the sinusotomy and the endoscopy was performed to evaluate adequacy or visualize the sinus cavity for disease, then the primary procedure would be best represented by the appropriate sinusotomy CPT procedure code. On the other hand, as a sinusotomy is usually required to accomplish a medically necessary diagnostic (or surgical) sinus endoscopy, the sinus endoscopy would be the primary (medically necessary) service and should be reported. *CPT Manual* narrative indicates that a surgical sinus endoscopy always includes a sinusotomy and diagnostic endoscopy.

5. Control of bleeding during a procedure is an integral part of endoscopic procedures and is not separately reported (e.g. CPT code 30901 for control of nasal hemorrhage is not to be reported with CPT code 31235 for nasal/sinus endoscopy, etc.). If bleeding is a late complication and requires a significant, separately identifiable service after the patient has been released from the endoscopic procedure, a separate service may be reported with the -78 modifier indicating that a related procedure was performed to treat a complication during the postoperative period.

6. When endoscopic procedures are performed, the most comprehensive code describing the service rendered is reported. If multiple procedures are performed and not adequately described by a single CPT procedure code, more than one code may be reported; however, the multiple procedure modifier -51 is attached to the appropriate secondary service CPT codes. Additionally, only medically necessary services are reported; incidental examination of other areas are not to be separately reported.

7. When laryngoscopy is required for placement of an endotracheal tube (e.g. CPT code 31500), a laryngoscopy code is not to be separately coded. Additionally, when a laryngoscopy is used to place an endotracheal tube for non-emergent reasons (e.g. general anesthesia, bronchoscopy, etc.) a separate service is not to be reported for the laryngoscopy. The CPT code 31500 refers only to endotracheal intubation as an emergency procedure and is not reported when an elective intubation is performed. When intubation is performed in the setting of a rapidly deteriorating patient who will require mechanical ventilation, a separate service may be reported with adequate documentation of the reasons for intubation.

8. When tracheostomy is performed as an essential part of laryngeal surgery, in accordance with the separate procedure policy, the CPT code 31600 is not separately reported. This would include laryngotomy, laryngectomy, laryngoplasty codes or other codes that routinely require placement of a tracheostomy.

9. If a laryngoscopy is required for the placement of a tracheostomy, the tracheostomy (CPT codes 31603-31614) is reported and not the laryngoscopy.

10. CPT code 92511 (nasopharyngoscopy with endoscopy) should not be reported as a distinct service when performed as a cursory inspection with other respiratory endoscopic procedures.

11. A surgical thoracoscopy is included in and not to be separately reported from an open thoracotomy when performed at the same session; the thoracotomy would represent the most extensive procedure successfully accomplished. If, however, the thoracoscopy was performed for purposes of an initial diagnosis and the decision to perform surgery is based on the results of

the thoracoscopy, then it is separately reported. The -58 modifier may be used to indicate that the diagnostic thoracoscopy and the thoracotomy are staged or planned procedures.

C. Cardiovascular System

1. Procurement of a venous graft is integral to the performance of a coronary artery bypass using venous bypasses. CPT codes 37700-37735 (ligation of saphenous veins) are not to be separately reported in addition to CPT codes 33510-33523 (coronary artery bypass).

2. When a coronary artery bypass is performed, the most comprehensive code describing the procedure performed should be used. When venous grafting only is performed, only one code in the group of the coronary artery bypass CPT codes 33510-33516 (venous graft only) can be reported; no other bypass codes should be reported with these codes. One code in the group of CPT codes 33517-33523 (combined arterial-venous grafting) and one code in the group of CPT codes 33533-33536 (arterial grafting) can be reported together to accurately describe combined arterial-venous bypass. When only arterial grafting is performed, only one code in the group of CPT codes 33533-33536 (arterial grafting) is coded.

3. When an intervascular shunt procedure is performed as a part of another procedure at the same site requiring vascular revision, a service for a shunt procedure is not separately reported from CPT codes 36800-36861 (intervascular cannulization/shunt). By *CPT Manual* definition, this series of codes represents "separate procedures" (see separate procedure policy in Chapter I, Section K).

4. An aneurysm repair may require direct repair with or without graft insertion, thromboendarterectomy and/or bypass. When a thromboendarterectomy is undertaken at the site of the aneurysm and it is necessary for an aneurysm repair or graft insertion, a separate service is not reported for the thromboendarterectomy. Additionally, if only a bypass is placed, which may require an endarterectomy to place the bypass graft, only the code describing the bypass can be reported. If both an aneurysm repair (e.g. after rupture) and a bypass are performed at separate non-contiguous sites, the aneurysm repair code and

the bypass code should be reported with an anatomic modifier or the -59 modifier.

If a thromboendarterectomy is medically necessary, due to vascular occlusion on a different vessel at the same session, the appropriate code may be reported, but should include an anatomic modifier or the -59 modifier, indicating that this represents non-contiguous vessels. At a given site, only one type of bypass (venous, non-venous) code can be reported. If different vessels are bypassed by different methodology, separate codes may be reported. If the same vessel has multiple obstructions and requires different types of bypass in different areas, separate codes may be reported; however, it will be necessary to indicate that multiple procedures were performed by using an anatomic modifier or the -59 modifier.

5. When an open vascular procedure (e.g. thromboendarterectomy) is performed, the closure and repair are included in the description of the vascular procedure. Accordingly, the CPT codes 35201-35286 (repair of blood vessel) are not to be reported in addition to the primary vascular procedure.

6. When an unsuccessful percutaneous vascular procedure is followed by an open procedure at the same session/same physician (e.g. percutaneous transluminal angioplasty, thrombectomy, embolectomy, etc. followed by a similar open procedure such as thromboendarterectomy), only the service for the successful procedure, which is usually the most extensive, open procedure is reported (see sequential procedure policy, Chapter I, Section N). In the case where a percutaneous procedure is performed at the site of one lesion, and an open procedure is performed at a separate lesion, the services for the percutaneous procedure should be reported with the -59 modifier only if the lesions are in distinct anatomical vessels.

7. The HCPCS/CPT codes 36000, 36406, 36410, 90784, etc. represent very common procedures performed to gain venous access for phlebotomy, prophylactic intravenous access, infusion therapy, chemotherapy, drug administration, among others. When intravenous access is routinely obtained in the course of performing other medical/diagnostic/surgical procedures, or is necessary to accomplish the procedure (e.g. infusion therapy, chemotherapy), it is inappropriate to bill separately for the

venous access services. The work of gaining routine vascular access is integral to and therefore included in the work value of the procedure. When the service is performed alone or a service does not routinely require vascular access, these codes may be separately reported. While this represents a general policy statement, specific policy statements are written for further clarification elsewhere. When transcatheter therapy services are performed, the placement of the needle and catheter are included in the primary service.

8. When (non-coronary) transluminal angioplasty or other transluminal procedure is performed at the same session/site as angiography, only one selective catheter placement code for the involved site should be reported. If the angiogram and the angioplasty or other transluminal procedure are not performed in immediate sequence and the catheters are left in place during the interim, a second selective catheter placement or access code should not be reported. Additionally, dye injections to position the catheter should not be reported as a second angiography procedure.

9. When a median sternotomy is performed to accomplish cardiothoracic procedures, the repair of the sternal incision is part of the primary procedure. The CPT codes 21820-21825 (treatment of sternum fracture) are not separately reported nor should the removal of embedded wires be reported if a repeat procedure or return to the operating room (e.g. postoperative hemorrhage on the day of surgery) is necessary.

10. When existing vascular access lines or selectively placed catheters are used to procure arterial or venous samples, billing for the sample collection separately is inappropriate.

11. Peripheral vascular bypass CPT codes describe bypass procedures using venous grafts (CPT codes 35501-35587) and using other types of bypass procedures (arterial reconstruction, composite). Because, at a given site of obstruction, only one type of bypass is performed, these groups of codes are mutually exclusive. When different sites are treated with different bypass procedures in the same operative session, the different bypass procedures may be separately reported, using an anatomic modifier or the -59 modifier.

12. Vascular obstruction may be caused by thrombosis, embolism and/or atherosclerosis as well as other conditions. Treatment may, therefore, include thrombectomy, embolectomy and/or endarterectomy; these procedures may be performed alone or in combination. CPT codes are available describing the separate services (CPT codes 34001 - 34203) and describing these services with thromboendarterectomy (CPT codes 35301 - 35381). Only the most comprehensive code describing the services performed for a given site can be reported; therefore, for a given site, a code from both of the above groups cannot be reported together. Additionally, in accordance with the sequential procedure policy, if a balloon thrombectomy fails, and requires a performance of an open thromboendarterectomy, only the more comprehensive service that was performed (generally the open procedure) is reported.

13. When percutaneous angioplasty of a vascular lesion is followed at the same session by a percutaneous or open atherectomy, generally due to insufficient improvement in vascular flow with angioplasty alone, only the column 1 atherectomy procedure that was performed (generally the open procedure) is reported (see sequential procedure policy, Chapter I, Section N).

14. CPT codes 35800-35860 are to be used when a return to the operating room is necessary for exploration for postoperative hemorrhage; accordingly, these codes are not to be coded for bleeding that occurs during the initial operative session. Generally, when these codes are used, they are to be reported with the -78 modifier indicating that the service represents a return to the operating room for a related procedure during the postoperative period.

D. Hemic and Lymphatic Systems

When bone marrow aspiration is performed alone, the appropriate code to report is CPT code 38220. When a bone marrow biopsy is performed, the appropriate code is CPT code 38221 (bone marrow biopsy); this code cannot be reported with CPT code 20220 (bone biopsy). CPT codes 38220 and 38221 may only be reported together if the two procedures are performed at separate sites or at separate patient encounters. Separate sites include bone marrow aspiration and biopsy in different bones or two separate skin incisions over the same bone. When both a bone marrow biopsy (CPT code 38221) and bone marrow aspiration (CPT code 38220) are

performed at the same site through the same skin incision, only the bone marrow biopsy (CPT 38221) should be reported.

E. General Policy Statements

1. Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475 and 90780 describe services that may be utilized for postoperative pain management. The services described by these codes may be reported only if performed for purposes unrelated to the postoperative pain management.

2. Medicare Anesthesia Rules prevent separate payment for anesthesia when provided by the physician performing a medical or surgical service. The physician should not report CPT codes 00100-01999. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or intravenous infusion (CPT code 90780) should not be reported when these services are related to the delivery of an anesthetic agent.